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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of:

**Thomas J. Grade, M.D.,**

-vs-

Holder of License No. 10424  
for the practice of allopathic Medicine in  
the State of Arizona, et al.,  
  
Respondent.

No. MD-05-0253A  
MD-04-0540A  
MD-04-0459A

**Interim Findings of Fact, Conclusions of  
Law and Order  
(Summary Restriction)**

The Arizona Medical Board having considered this matter at its public meeting December 7, 2005. After reviewing relevant information and deliberating, the Board considered proceedings for summary action against the license of Thomas J. Grade, M.D. appearing with legal counsel, Lisa Davis. Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusion of Law and Order for Summary Restriction of License pending formal hearing or other Board action pursuant to A.R.S. 32-1451(H).

**INTERIM FINDINGS OF FACT**

1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. Thomas J. Grade, M.D. ("Respondent") is the holder of License No. 10424 for the practice of allopathic medicine in the State of Arizona.
3. On May 13, 2005, the Board received a complaint from AM concerning the care and treatment rendered by Respondent to a 41-year-old female patient, LM, the daughter of the complainant. Board staff opened investigation number MD-05-0253A.
4. LM went to see Respondent on April 20, 2004, with a complaint of back pain. She

- 1 had been utilizing a spinal cord stimulator for pain relief and the battery had run  
2 out. She was referred to Respondent to replace the battery.
- 3 5. Respondent conducted a physical examination and reviewed LM's history  
4 including a listing of medications she was currently prescribed and taking.
- 5 6. Respondent scheduled LM for battery replacement on April 26, 2004 and  
6 prescribed Roxane Methadone 10 mg tablets with instructions to take one to three  
7 tablets four times per day for chronic pain. Respondent prescribed 200 tablets.
- 8 7. Respondent's office notes indicated that LM should start with five to ten mg per  
9 day and gradually increase the dose and replace the oxycontin she was taking with  
10 the methadone. However, the prescription read that LM should take a minimum of  
11 ten mg four times per day and could take as much as thirty mg four times per day.
- 12 8. At the time Respondent saw LM, she was already taking oxycontin 80 mg twice  
13 per day as well as multiple other medications including neurontin, zanaflex, paxil,  
14 amitriptyline and ambien.
- 15 9. Respondent did not discuss LM's treatment with her previous physician who had  
16 discharged LM for failing to adhere to stipulations in her narcotics contract.
- 17 10. Although Respondent says he advised LM about warnings for the medications,  
18 there is no mention of this within the patient medical charts. Respondent did not  
19 dictate the patient notes until April 29, 2004.
- 20 11. Respondent says that LM did not disclose all of the medications she was using at  
21 the time.
- 22 12. Respondent believed at the time that he was taking over LM's pain management.  
23 However, he did not obtain the patient's previous medical records at the time  
24 before prescribing the methadone and increasing the neurontin prescription.
- 25 13. On April 26, 2004, LM was found dead in her home. An autopsy concluded that  
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- 1 LM died from the toxicity of multiple drugs.
- 2 14. Standard of care requires a physician to maintain adequate records reflecting  
3 appropriate warnings regarding usage of prescription medications, obtain medical  
4 records from previous treating physicians to understand current treatment, to  
5 appropriately consider interaction of all medications and to appropriately  
6 introduce new opioid medication to a patient.
- 7 15. Respondent failed to record any discussions he had with LM relating to the  
8 precautions necessary when taking methadone, failed to obtain records from prior  
9 treating physicians, failed to appropriately prescribe methadone to indicate a  
10 gradual increase in dosage with a corresponding reduction in oxycontin.
- 11 16. On April 12, 2004, the Board received a complaint regarding Respondent's  
12 treatment of AH relating to pain management prescribing practices. Board staff  
13 opened investigation number MD-04-0459A.
- 14 17. The investigation concluded that Respondent failed appropriately document  
15 allegations of patient abuse of medications as well as quality of care issues by  
16 failing to monitor the patient's use of controlled substances for pain management  
17 and failure to initiate detoxification once alternative treatments were introduced.
- 18 18. On April 30, 2004, the Board received a complaint regarding Respondent's  
19 treatment of BE relating to pain management prescribing practices. Board staff  
20 opened investigation number MD-04-0540A.
- 21 19. The investigation concluded that Respondent failed to document physical  
22 examinations during his treatment of BE, failed to document current medications  
23 the patient was taking, failed to clearly outline treatment plans, advice, warnings  
24 or indications of how medications were to be changed, over-prescribed Oxycontin  
25 and Oxycodone with refill prescriptions written the same date as the original  
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1 prescriptions and failed to address the patient's tachycardia present on multiple  
2 visits.

3 **INTERIM CONCLUSIONS OF LAW**

4 20. The Board possesses jurisdiction of the subject matter hereof and over the  
5 Respondent, holder of license number 10424 for the practice of allopathic  
6 medicine in the State of Arizona.

7 21. The conduct and circumstances described above constitute unprofessional conduct  
8 pursuant to A.R.S. § 32-1401(27)(e) "failing to maintain adequate records on a  
9 patient."

10 22. The conduct and circumstances described above constitute unprofessional conduct  
11 pursuant to A.R.S. § 32-1401(27)(q) "Any conduct or practice which is or might  
12 be harmful or dangerous to the health of the patient or the public."

13 23. The conduct and circumstances described above constitute unprofessional conduct  
14 pursuant to A.R.S. § 32-1401(27)(ll) "Conduct the Board determines is gross  
15 negligence, repeated negligence or negligence resulting in harm to or the death of  
16 a patient."

17 24. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the  
18 public health, safety or welfare imperatively requires emergency action. A.R.S.  
19 32-1451(D).

20 **ORDER**

21 Based on the foregoing Interim Findings of Fact and Conclusions of Law,  
22 set forth above, IT IS HEREBY ORDERED THAT:

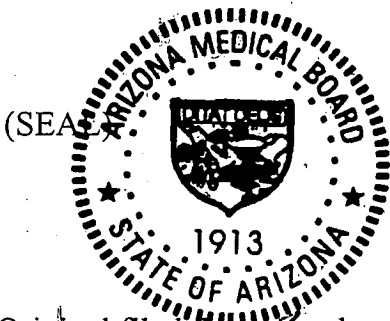
- 23  
24 1. Respondent's license number 10424 for the practice of allopathic medicine  
25 in the State of Arizona is summarily restricted in that Respondent may not  
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1 prescribe Schedule II or III medications pending formal hearing before an  
2 Administrative Law Judge from the Office of Administrative Hearings.

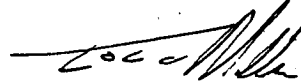
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4 2. The Interim Findings of Fact and Conclusions of Law constitute written  
5 notice to Respondent of the charges of unprofessional conduct made by the  
6 Board against him. The Respondent is entitled to a formal hearing to defend  
7 these charges as expeditiously as possible after the issuance of this Order.  
8

9 3. The Executive Director is instructed to refer this matter to the Office of  
10 Administrative Hearings for scheduling an administrative hearing to be  
11 commenced as expeditiously as possible from the date of issuance of this  
12 Order, unless stipulated or agreed otherwise by Respondent.  
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15 DATED AND EFFECTIVE this 8 day of December, 2005.



Arizona Medical Board



Timothy C. Miller, J.D.  
Executive Director

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20 Original filed this 8 day of  
21 December, 2005, with:

22 Arizona Medical Board  
23 9545 East Doubletree Road  
24 Scottsdale, AZ 85258

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1 Executed Copies of the foregoing were  
2 Mailed By U.S. Certified Mail  
3 this 8 day of December, 2005, to:  
4 Ms. Lisa E. Davis, Esq.  
5 *Quarles & Brady Streich Lang, L.L.P.*  
6 Two North Central Avenue  
7 Phoenix, Arizona 85004-2391  
8 Attorney for Respondent  
9 Thomas J. Grade, MD  
10 6209 East Baywood Avenue  
11 Mesa Arizona 85206-1744  
12 Dean E. Brekke  
13 Office of Arizona Attorney General  
14 1275 W. Washington CIV/LES  
15 Phoenix Arizona 85007

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